Form 2124C (5/13)

Photocopy Locally

The information obtained from this report will be maintained as confidential Quality Assurance information pursuant to Article 30, Section 3004A and 3006 of the Public Health Law of the State of New York

NEW YORK STATE – DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

AED INCIDENT REPORT

FACILITY/Office :_____ **DATE:**_____

INCIDENT DETAILS

PATIENT NAME:_____

PATIENT DOB:_____ PATIENT AGE:_____ PATIENT SEX:_____

INCIDENT DATE:_____ INCIDENT TIME:_____ am / pm

INCIDENT LOCATION:_____

EVENT HISTORY

Patient activity prior to event:_____

Patient Complaints prior to event:_____

Was the event witnessed? No Yes, at _____(time) / Witness_____

Was CPR started? No Yes, at _____(time) / Rescuer_____

TREATMENT AND OUTCOME (on site)

Were ABCs assessed? No Yes, at _____(time) / Rescuer_____

Was CPR initiated? No Yes, at _____(time) / Rescuer_____

Was patient defibrillated? No Yes, at _____(time) / Rescuer_____

Was pulse restored? No Yes, at _____(time) / Rescuer_____

Was respiration restored? No Yes, at _____(time) / Rescuer_____

Was consciousness regained? No Yes, at _____(time) / Rescuer_____

Was patient transferred to EMS? No Yes, at _____(time) / EMS Unit_____

Report completed by:_____ Date:_____

Reviewed by:_____ Date:_____

Superintendent/Regional Director or designee

This form is to be completed immediately following an AED use by the AED Operator and forwarded within 24 hours by the Facility AED Coordinator or designee to the Agency EHCP with the AED.